MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

SENTINEL/SIGNIFICANT EVENT REVIEW

Effective Date: February 20, 2003 **Policy #:** QI-05

I. PURPOSE: To provide guidelines for conducting a risk-prevention analysis in response to significant or sentinel events.

II. POLICY: In the event of a sentinel event or other significant occurrence that may indicate a serious problem in hospital operations exists, an appropriate review will be conducted to analyze why the problem occurred and what could be done to prevent a recurrence.

III. DEFINITIONS:

Root Cause Analysis means a thorough evaluation of the underlying and less than obvious reasons for the occurrence of a sentinel or other significant event.

Sentinel Event is an occurrence that has resulted or could have resulted in unanticipated death, psychological injury, or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or was one of the following:

Suicide of a patient

Confirmed sexual assault of a patient

Deliberately set fire

Unauthorized leave by a patient confined to a locked unit

Serious assault on a patient or staff member

Significant Event is an occurrence that may not meet the definition of a sentinel event, but for which a root cause analysis will be done to reduce risk of recurrence.

IV. RESPONSIBILITIES:

Director of Quality Improvement – to coordinate sentinel and significant event review procedures.

Hospital Administrator – to ensure collaboration and cooperation of all staff members and hospital departments in review and follow-up activities.

V. PROCEDURE:

1. All hospital staff members are to report occurrences that might be sentinel or significant events to the Hospital Administrator and Director of Quality Improvement.

2. The Hospital Administrator and the Director of Quality Improvement will determine whether a review will be conducted and the scope of the review. Either party may begin the process independently if the other is not available.

3. Immediate interventions will be provided to ensure the safety of any patients or staff involved.

4. Communication and disclosure to the relevant parties, including involved patients and their families or guardians, will be carried out by appropriate staff members, based on the situation.

5. Emotional support and problem solving help will be provided to patients and staff involved in a sentinel or significant event as needed.

6. The review of sentinel or significant events will be in the form of a root-cause analysis looking at all factors that may have contributed to the occurrence including those that may be indirect and less than obvious, but nonetheless significant. Review procedures may be modified to meet specific needs.

7. Review procedures will begin as soon a practical after an event is reported and will be concluded as soon as possible. However, the need to be thorough and objective will be the overriding determinate of how long the process will take.

8. The outcome of findings will be reported to the Hospital Administrator when the report is concluded and to the Quality Improvement Committee at the next scheduled meeting. Findings may be reported to other relevant individuals and hospital committees as indicated.

VI. REFERENCES: Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

VII. COLLABORATED WITH: Hospital Administrator, Director of Quality Improvement

VIII. RESCISSIONS: None

IX. DISTRIBUTION: All hospital policy manuals

X. REVIEW AND REISSUE DATE: February 2006

XI. FOLLOW-UP RESPONSIBILITY: Director of Quality Improvement

XII. ATTACHMENTS: None

_____/___/__	_____/___/__
Ed Amberg Date	Connie Worl Date
Hospital Administrator	Director of Quality Improvement